STATE OF VERMONT

HUMAN SERVICES BOARD

In re) Fair Hearing No. 12,136

)

Appeal of)

)

)

INTRODUCTION

The petitioner appeals the decision by the Department of Social Welfare denying his request for reimbursement for out-of-pocket medical expenses the petitioner paid while his medicaid application was pending. The issue is whether the Department's regulation that prohibits such reimbursement is contrary to the federal medicaid statute that requires states to provide medical assistance to all eligible recipients on an equal basis.

FINDINGS OF FACT

The facts are not in dispute. The petitioner applied for medicaid in January, 1993, on the basis of disability. Pursuant to regulations his initial eligibility could be retroactive to October 1, 1992, if he met all eligibility criteria as of that date. In March, 1993, the Department determined that the petitioner met the disability test for medicaid, but advised the petitioner that he had to provide further information in order to determine his financial eligibility. The petitioner submitted this information in a timely manner, and on April 20, 1993, the Department

notified him that he was eligible for medicaid retroactively to October 1, 1992.

Throughout the time that his medicaid application was pending, and back to October 1, 1992, the petitioner bought and paid for prescription medications at his regular pharmacy. When he was found eligible for medicaid for this period he asked the Department to reimburse him for those out of pocket expenditures. The Department advised the petitioner that under its regulations it could not reimburse the petitioner directly, but that the petitioner could ask his pharmacy to submit the bills to medicaid and reimburse him for the cash payments he had made to the pharmacy.(1)

However, medical providers are not required to submit retroactive medicaid claims and to reimburse

individuals who pay cash for covered services during a period for which those individuals are retroactively found eligible for medicaid. Nonetheless, according to the Department, many providers will voluntarily do this as a service to their customers, even though the medicaid payment rates are usually lower than what they charged those individuals as cash-paying customers. Unfortunately for the petitioner, his pharmacy has a policy of not accepting medicaid retroactively for prescriptions that have previously been paid in cash.

Under the medicaid regulations, however, if the petitioner had obtained his prescriptions during this time on credit, his pharmacy would have been required to submit the claims to medicaid, and the petitioner would not have been personally liable to the pharmacy for payment. When he bought the prescriptions in question the petitioner was unaware of either the Department's or his pharmacy's policies regarding reimbursement.(2)

ORDER

The Department's decision is reversed.

REASONS

Medicaid Manual (MM) § 152 provides as follows:

Medical Services

The Department pays providers for Medicaid Services through a fiscal agent. To receive payment, the provider must send a claim to the fiscal agent subject to the limitations and conditions specified in Sections M154-M159.

The Department will reimburse a Medicaid recipient for his/her out-of-pocket expense for covered medical services under the following conditions only:

The recipient applied for benefits after February 15, 1973, and was denied; and

The recipient was later granted Medicaid as a result of any review of the initial denial which resulted in its reversal (e.g. quality control review, supervisory review, SSI appeal, appeal and reversal by the Human Services Board, or any other identification of an error in the original determination which results in its reversal.

Reimbursement is for 100 percent of the out-of-pocket expenditures made by a recipient or a member of his/her Medicaid group for Medicaid-covered services provided between the date of eligibility (which may be as early as the first day of the third month before the month of application) and the date the recipient's first Medicaid ID was made available to him/her (when this date cannot be determined otherwise, use the second mail delivery day following the date the first Medicaid ID was mailed). No co-payment is due.

Payment cannot otherwise be made direct to a Medicaid recipient, even if he/she has already paid the provider for a covered service. When Medicaid coverage is granted after bills have been paid (for example, through application for retroactive coverage), the recipient may ask the provider to bill

Medicaid and refund the recipient's payment. If the provider agrees to do so, he/she must accept the Medicaid allowance and refund the full amount of the recipient's payment (see also Provider Responsibility).

There is no question that under the above regulation the Department is not required to reimburse the petitioner for the prescriptions he bought and paid for either while his medicaid application was pending or during the three-month period of retroactive eligibility that preceded the date of his application. The petitioner maintains, however, that the above regulation is inconsistent with the federal medicaid statutes and that it violates his right to equal protection under the United States and the Vermont Constitutions.

The pertinent federal medicaid statute, 42 U.S.C. § 1396a(a)(10)(B), provides that medical assistance that is provided to one individual under the medicaid program shall not be less in amount, duration, or scope than the assistance provided to any other individual enrolled in the program. The Board agrees with the cases cited (and copied) by the petitioner in his written arguments that the above provision prohibits the creation of different classes of individuals, some of whom are eligible for reimbursement and others who are not. See Kreiger v. Krauskopf, 503 N.Y.S. 2d 418 (1986), Affd., 70 N.Y. 2d 637 (1987). Under MM § M152, supra, individuals like the petitioner who pay for medical services during the pendency of their initial determinations are ineligible for medicaid to cover those services unless their provider elects to reimburse them. However, similarly situated individuals who receive medical services without paying for them, or who pay for services but are fortunate enough to have a provider who will reimburse them, are eligible for medicaid coverage for those same services. Such blatant discrimination is clearly proscribed by the above federal statute.

Moreover, not only does § M152 unfairly single out individuals like the petitioner who pay cash to a provider who does not offer reimbursement, the Department also provides no advance notice whatsoever to such individuals that they will be penalized by doing so.

By the fact that MM § M152 specifically allows reimbursement directly to some recipients (i.e., those whose initial denials are reversed on appeal) the Department cannot maintain that there exists in the law a blanket prohibition on recipient, as opposed to provider, reimbursement.(3) The fact that the regulation allows reimbursement to individuals whose initial application was denied, but denies it to individuals, like the petitioner, whose initial applications are granted, is also, in and of itself, the type of discrimination prohibited by the federal statute (supra).

The Department could, if it chose, require providers to accept medicaid payment for services already paid for by individuals while their medicaid applications are pending--whether initially or on appeal--and require providers to reimburse those individuals for all previously-paid-for services that are retroactively subject to medicaid coverage. See MM § M154. As it stands now, however, the Department leaves it solely to providers to determine which individuals will be reimbursed. Not only is this discriminatory (see supra), it is also an abdication of the Department's responsibility under § M150.2 of the regulations "to assure that mechanisms exist for the payment of reimbursable expenses".

For the above reasons § M152, as it applies to the petitioner's situation, must be considered invalid as a matter of law.(4) The Department's decision is, therefore, reversed.

# # #

1. Because medicaid eligibility is determined for six-month periods, by the time the petitioner was found eligible, his first six-month period (beginning October 1, 1993) had expired, and it was necessary for the Department to also determine the petitioner's eligibility for a new six-month period, commencing April 1, 1993. Although the financial documentation submitted by the petitioner was sufficient to also determine him eligible as of April 1, 1993, the Department did not notify the petitioner of his eligibility for this period until May 14, 1993. The Department concedes, however, that under the regulations it should have notified the petitioner by May 2, 1993, of his eligibility for the period commencing April 1, 1993, and it has agreed to reimburse the petitioner for any out of pocket covered medical expenses that he incurred between May 2 and May 14, 1993.

2. The only "notice" the Department provides to applicants regarding this policy is in a four-page pamphlet of general medicaid information, which is apparently sent to applicants only after they are found categorically eligible for medicaid. (It appears, however, that the pamphlet may be available as part of a display of general information that visitors to the Department's district offices can pick out and take with them.) The Department maintains that this pamphlet was sent to the petitioner with its March 19, 1993, notice to the petitioner that he had met the disability criteria for eligibility. The relevant portion of the pamphlet contains this provision:

The Medically Needy Program may also be able to pay your unpaid medical bills for services received in the three months before the month you apply.

3. The sole instance of medicaid reimbursement available directly to an individual recipient in this regulation--i.e., when the initial decision of the Department is later reversed on appeal--appears to be the result of a 1980 Vermont Superior Court decision requiring the Department to make reimbursement in such circumstances. Gearwar et. al v. Commr. of D.S.W., Washington Superior Court, Dkt. No. S60-79-Wnc. However, that court decision did not consider the situation presented herein--i.e., whether reimbursement is available for out-of-pocket expenditures by an applicant while he is awaiting the Department's initial decision in his case.

4. Because it is concluded that § M152 violates the federal medicaid statutes the board need not reach the constitutional issues raised by the petitioner. It can be observed, however, that even if § M152 could be found to be not inconsistent with the federal statutes, it appears to be indefensible as a matter of any constitutional notion of fundamental equity.